A commentary on the quality improvement practices in leading an organizational response to audit feedback

Dr Michael Sykes

Michael.sykes@Northumbria.ac.uk

Department of Nursing, Midwifery and Health, Northumbria University, Newcastle upon Tyne, United Kingdom

Abstract

Clinical audit is commonly used to assess and improve the quality of care. The impact of clinical audit on practice could be improved by supporting the ability of people who receive feedback from audits to mount effective responses. This article, written for people who receive feedback, audit providers and quality improvement leads, describes important practices in the organisational response to feedback. The practices were identified through work to describe the current response to national audit and draw upon theory-informed hypotheses for enhancing audit and feedback. Both the content and implementation of the practices were co-designed with stakeholders and tested alongside different national audits. The identified quality improvement practices provide practical guidance for feedback recipients and enable providers and quality improvement leads to consider the capabilities required for such practices. The approach resonates with organisational readiness to change theory, proposing that informational appraisal and change commitment underpin effective improvement actions.

Manuscript Highlights

What is known about the topic?

- Audit may lead to greater improvement if feedback recipients receive support for their quality improvement capabilities
- Common improvement methods recommend 'planning' to improve, often including a 'situational analysis'
- Improvement methods are sometimes not specified or reported in a way that enables replication

What does this paper add?

- Describing the specific practices within the quality improvement response provides practical guidance to support feedback recipients
- Describing the specific practices supports audit providers and quality improvement leads to consider the capabilities required for such practices
- This paper proposes practices that tailor the response to local context and resonate with Organisational readiness to change theory.

Background:

Clinical audit, also known as audit and feedback, seeks to improve care by reviewing clinical practice against an explicit standard and providing a summary of performance over a period of time[1]. The main commissioner of English national audit states that, "health care providers require additional support to make best use of performance feedback data"[2]. Stakeholders prioritise the importance of recipients having the capabilities to respond to the feedback[3], and theory points to effectiveness of audit and feedback being associated with health professionals' quality improvement capabilities[4]. This article, written for feedback recipients, audit providers and quality improvement

leads, describes considerations for the content and delivery of support to feedback recipients, and provides an 'action model' for feedback recipients to plan their organisational improvement activity. An action model, "provides practical guidance in the planning and execution of implementation endeavours and/or implementation strategies to facilitate implementation"[5]. There are different levels of organisation, this article is written for people at team, division, hospital or hospital/practice group level.

Improvement methods are sometimes not specified or reported in a way that enables replication[6]. Theory-informed methods are recommended, but not always applied[3]. This article will describe an evidence-based and theory- and stakeholder-informed method for enhancing organisational response to audit feedback. The article draws upon work to develop an action model of the practices involved in enhanced organisational response to audit[7], as well as wider literature. The action model (Figure 1) was co-designed using data describing the current response to a national audit from diverse hospitals and theory-informed hypotheses describing how to enhance audit[8]. The action model specifies the quality improvement practices that inform, and develop commitment for, the response to audit feedback. The action model was then refined through feasibility and co-design studies aligned to two national audits (diabetes and dementia)[7]. The model describes practices to appraise information and generate

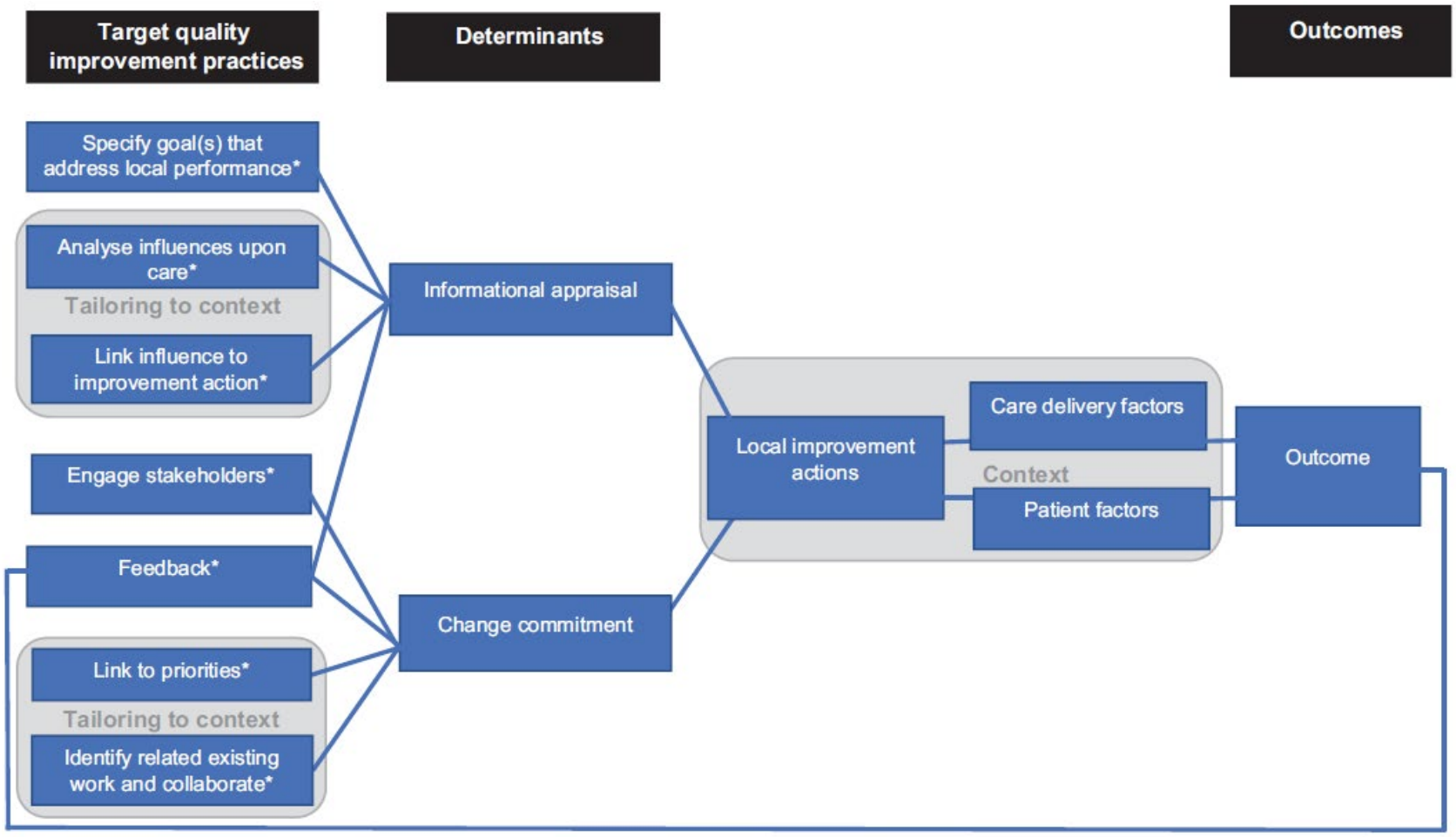

Figure 1: A co-designed action model of an enhanced organizational response to audit feedback v2. [* indicates the practices requiring stakeholder engagement]

change commitment and resonates with Weiner's Organisational readiness to change theory[9]. The practices are intended to be undertaken by a multidisciplinary team including a clinical lead appropriate to the organisational level of the feedback.

Select target and specify goal(s) that address local performance

Improvement capacity is limited, this creates an opportunity cost of those clinical audit standards that are not prioritised for improvement. When selecting priorities, we found that national audit recipients were influenced by national priorities, often undertaking improvement activities on these standards in spite of having high performance and at the expense of ones with weaker local performance[8]. Selecting the target for improvement could be enhanced by reviewing local absolute and relative (that is, compared to somewhere else) performance and considering impact upon outcomes. Analysis of local performance may identify sub-populations where improvement may both have the greatest impact on performance and serve to reduce inequalities. For example, the English and Welsh national diabetes audit describes differences in the use of guideline-recommended insulin pumps by age, sex, ethnicity and social deprivation[10].

After selecting the target for improvement, specify the goal(s), that is, the behaviour(s) to be achieved. Goals are specified by identifying the action, actor, context, target, time[6]; for example, a goal to address gaps in delirium screening might be specified as, all patients over 65 (target) will be screened for delirium using the 4AT tool (action) by a nurse (actor) within 6 hours of admission (time) to the hospital (context). There may be multiple goals that reflect the pathway behind performance in the standard being addressed. The specification of the goal(s), as with the other practices in our action model, involves stakeholder engagement.

Engage stakeholders

Engaging stakeholders provides more perspectives upon: the goal; influences upon the goal; and actions to meet the goal. Engaging stakeholders may help to develop commitment[9]. Such social aspects of improvement are as important as technical aspects but can be challenging[11]. Stakeholder engagement in the organisational response to national audit currently includes discussions with a positional leader (e.g. an associate director of nursing), an existing group related to the audit topic (e.g. discussing the national audit with the dementia steering group) and presentation at organisation-level committee(s)[8].

Stakeholder analysis[12] may help identify a broader range of stakeholders to engage. This analysis can be applied to stakeholders in the audit results, in related priorities (see below) and, later, to stakeholders in the draft actions. We found that stakeholders were keen to discuss data quality, including consideration of the data source, method of collection and triangulation with other data (e.g. complaints data)[8].

Stakeholders should be asked how best to engage them. Stakeholder engagement might be enhanced by including both informal face-to-face discussions and presentation at committees. These discussions should include a brief description of the source and method of the audit[8]. The informal discussion may be enhanced by those involved in this discussion giving their perspectives upon:

- current performance, the reason for selecting the target and the care practices behind that target;
- personal and organisational priorities and how they relate to the audit data;
- influences upon performance;
- how to improve;
- existing actions related to the response to feedback;

- additional stakeholders in the proposed actions and goals.

Discussion of what change might mean for the stakeholders personally may help explore influences upon commitment and support them to consider the skills and resources to enact a change[12]. Where organisational approval for the response is required, the above topics should be incorporated into the presentations at formal committees with responsibility for monitoring, or leading improvement in, quality.

Analyse influences upon care

Understanding what influences performance provides the foundation for selecting actions to improve[13,14,15]. Currently, there may not be a structured analysis of influences upon performance[8]. Such an analysis could involve discussions with stakeholders, observations of practice and/or systematic review. The use of theory (e.g. Normalisation Process Theory[13]) or a framework (e.g. the Theoretical Domains Framework[14]) may enhance the analysis of influences upon performance.

Consideration of how to undertake this analysis might include negotiation of resources; for example, through time within job plans, through a junior doctor improvement project required for accreditation or with corporate quality improvement team support. Engaging stakeholders in the analysis can provide broader perspectives upon influences resulting in the selection of more effective improvement actions, and may start to develop buy-in to the actions.

Link influence to improvement action

Tailoring actions to influences can address barriers and facilitators to performance[15]. Currently, team leads select actions based upon what they could do personally[8] which may be unlikely to address underlying influences upon performance. Selecting actions in this way may reflect their beliefs about capabilities; for example, their beliefs about others' ability to act or their own capability to gain commitment from others. This article

proposes that the alignment between the influence and the action could be enhanced through the use of logic models. Logic models articulate the underlying theory of change[15], describing how an action addresses an influence. Drawing a logic model may help clarify the proposed link between the influence and the action. The logic model may also help to communicate the link to others as part of the work to develop commitment for the improvement action.

Link to priorities

Commitment can be at different levels, for example, from individuals, or at team or hospital level[13]. Organisational commitment refers to a, "shared resolve to pursue the courses of action involved in change implementation"[9] (p2). Organisational commitment is developed through discussions and includes consideration of risks to priorities, notably regulatory, reputational and financial objectives[8]. Considering stakeholders' priorities and presenting information linking the need for improvement and the proposed actions to those priorities may help to generate commitment[7]. For example, describing how the work influences patient wellbeing, efficiency and/or individual or organisational reputation may make it easier for stakeholders to commit to improvement. Presenting comparison data (e.g. how this team compares to another team) may help stakeholders consider whether they are meeting their aim to be a high performing team[16].

Espoused organisational priorities are often documented in strategy or workplan documents; for example, national strategies to reduce inequalities, organisational visions, strategic goals to be high performing or ward mission statements to provide safe and effective care. Currently, clinicians may be unaware of these priorities[7]. Feedback recipients could seek conversations with people who might be aware of the local organisational priorities (e.g. clinical director, associate director of nursing) and

review organisational documents, in order to identify priorities linked to the target for improvement and/or the improvement action.

Identify related existing work and collaborate

Audit and feedback may lead to greater improvement when the costs involved in making changes are lower[3,4]. Implementation may be easier if task demands are acceptable[9]. Explicit consideration of workstreams related to the standard for improvement, the goal(s) or the improvement action may both link the work to existing priorities and reduce the cost of change interventions. For example, if performance is influenced by health professionals' memory, linking the audit to existing work to amend the health record may provide a low-cost way to build in prompts that address the influence of memory. Seeking collaborations with related teams who have undertaken similar work may reduce costs associated with the change; for example, the time cost of developing training materials or writing business cases.

Monitor feedback

Changes do not always lead to improvement. In line with work describing the cyclical nature of audit and plan-do-study-act[17, 18], this article proposes monitoring the change, where possible using existing audit data. Monitoring should be frequent, presented in writing and verbally, and should be discussed with stakeholders in groups[1]. The aims from monitoring discussions are to evaluate the impact of changes and inform decisions about the need for further action. If new feedback mechanisms are needed (e.g. to gain frequent feedback), allow time and resources for set-up[11].

Discussion

This paper summarises how the response to audit feedback may be enhanced and seeks to provide practical guidance to support feedback recipients by specifying

practices in the response to feedback. The action model is similar to previous approaches to improvement, for example:

- by setting a goal and using a cyclical approach similar to plan, do, study and act[17, 18].
- by considering selecting targets for improvement based upon performance and impact and specifying goals informed by stakeholder engagement the action model resonates with failure modes effect analysis[19] (failure mode, likelihood, failure effects, cause of failure).

However, the action model provides greater specificity of the practices within the planning[18] or situational analysis stage[20]. Importantly, the action model also gives explicit consideration of commitment to change, an under-addressed component[11]. In doing so, it responds to work describing current responses to national audit[8], to calls to provide additional support to feedback recipients[2] and to papers describing the opportunity to enhance response to audit and feedback by developing feedback recipients' quality improvement capabilities[3,4].

By describing practices in the organisational response, this paper aims to support feedback providers and quality improvement leads to consider influences upon the implementation of these improvement practices; for example, the barriers and facilitators to clinical leads engaging stakeholders or exploring influences upon clinical performance. Important barriers and facilitator to implementation included how feedback recipients differentiate the approach from current practice, how they work with others to organise themselves to participate in a new practice and how they buy-in to the new approach[7]. Theory-informed co-design work identified that implementation may involve demonstration of the practices, supporting feedback recipients to plan how and when to carry them out and a credible source communicating in favour of the practices[7]. Creating both the physical opportunity (e.g. time[11]) and social opportunity to

collaborate were important[7]. Quality improvement collaboratives incorporating educational workshops and facilitated multisite meetings provide a structure to deliver these capabilities[7].

There are strengths and limitations to the proposed action model. The action model was co-designed iteratively through stakeholder discussions of evidence and theory and feasibility tests in different national audits[7]. The model describes the quality improvement practices that inform, and develop commitment for, the response to audit feedback. There are potential limitations of the action model: Theory describing how audit and feedback might lead to improvement describes earlier stages than those addressed within the co-designed approach. As such, there may be further enhancements, for example, relating to the nature of the feedback and steps leading to the intention to change[4]. The action model focusses on how feedback recipients develop an organisational response; different practices may enhance individual or national responses to feedback. The action model is a simplification describing stronger relationships between selected components. It is anticipated that there are further interactions (e.g. consideration of existing work may affect both the assessment of opportunity cost proposed to influence commitment and the informational appraisal of potential improvement actions). The intervention may reflect the English healthcare context; current work is seeking to adapt the action model to a different national context. There is the opportunity to specify further the practices within the model, for example, who will analyse influences upon performance, where, when and with what materials. However, further specification may be context-specific. Instead, this paper uses a level of abstraction that both provides clarity and supports adaptation. Moore and colleagues provide guidance on how to undertake such adaptation[21].

Conclusion

There is evidence, theory and policy for the need to support audit feedback recipients to improve care. Specifying important practices within the quality improvement response provides an action model for feedback recipients and enables audit providers and quality improvement leads to consider how such practices might be implemented. The action model presented here will be further refined through work to extend its application, content and delivery.

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